Chapter Five

Medicare and Medicaid: Deficit Reduction and Program Restructuring

Federal health care costs have escalated sharply over the past two decades, accounting for an increasing share of the budget. Medicare and Medicaid, which finance the health care of millions of Americans, are among the largest entitlement programs; only Social Security is larger. In 1997, federal spending on Medicare and Medicaid is expected to exceed $300 billion.

The growth in federal spending for Medicare and Medicaid has slowed recently, but there is no indication of any significant change in the factors driving spending in the two programs. In Medicare, efforts to slow the growth in payments to some providers have had a degree of success. But those efforts have also created incentives to channel patients into alternative settings that are paid on a less restrictive basis. In Medicaid, some of the recent slowdown reflects states' responses to proposals to reform that program and may be temporary. Moreover, despite lower short-term projections of enrollment, inflation, and use of services, pressures for higher spending are likely to reemerge over the next few years.

Federal health spending is projected over the long term to rise faster than the growth in the nation's ability to pay for those services. By 2003, federal spending on the two health care entitlements is projected to top Social Security spending. The outlook beyond 2010 is considerably bleaker because of strong demographic pressures arising with the aging of the baby-boom generation.

The United States is currently in a period of historically low growth in Medicare enrollment as the baby-bust generation, born during the Depression and war years of the 1930s and 1940s, reaches age 65. Only after 2010, when the first wave of the baby-boom generation reaches 65, will Medicare enrollment begin a period of exceptionally swift growth lasting two decades. Demand for services under Medicare will increase dramatically during that time, as succeeding baby-boom cohorts continue to enter the program through 2030. In addition, the number of low-income elderly people eligible for Medicaid, already growing considerably faster than the elderly population overall, will also swell. The demand for long-term care services covered by Medicaid is likely to mount substantially thereafter.

We are thus in the calm before the storm. Pressure for budget stringency in Medicare is much lower than it was last year. Many people have pointed to the slowdown in Medicaid spending to argue against any significant policy changes for the 1998 budget. But this fiscal pause obscures the fact that both programs must prepare--in a relatively short amount of time--for the unprecedented demands of the baby-boom generation. Policies put into place over the next several years could provide the deficit reduction necessary in the short

term and start the restructuring essential for the programs over the longer term.

The discussion of Medicare in these pages departs from the format used in earlier chapters. For example, instead of pinpointing individual policies and their associated savings estimates as stand-alone options, this chapter develops integrated packages of Medicare options that could achieve total savings of $100 billion and $150 billion over the next five years. That approach highlights the trade-offs and interactions that policymakers must consider when folding detailed policies into a comprehensive Medicare proposal.

The discussion of Medicaid also takes a broad perspective on containing federal costs, reflecting the nature of policy debate over the past several years. Rather than consider narrow options that might explicitly alter eligibility, coverage, or specific spending rules in Medicaid, this chapter addresses two policies--block grants and per capita caps--that would change the present fiscal relationship between federal and state governments. Other policies--reductions in disproportionate share payments and reductions in federal matching rates--would not change that relationship but could yield federal savings.

I. Medicare

Medicare consists of two related programs: Hospital Insurance (HI), or Part A, which covers certain costs of hospital stays and post-acute care services; and Supplementary Medical Insurance (SMI), or Part B, which primarily pays for the services of physicians and other providers of outpatient health care. Over the past decade, Medicare spending has grown more quickly than every other major federal spending program except Medicaid. In 1997, Medicare will provide over $200 billion in benefits to 38 million elderly and disabled people.

Under current law, the Congressional Budget Office (CBO) projects that Medicare spending will soar to nearly $470 billion by 2007 (see Table 5-1). That growth represents an average annual rate of increase of 8.3 percent over the next decade, compared with the projected 4.7 percent growth in the economy over the same period.

The two programs receive their funding from different sources. HI benefits are financed primarily from payroll taxes paid by current workers and their employ-

Table 5-1.
Projections of Medicare Outlays (By selected fiscal year)

	Outlays (Billions of dollars)			Average Annual Rate of Growth, 1997-2007 (Percent)
	1997	2002	2007	
Hospital Insurance	137	202	290	7.7
Supplementary Medical Insurance	75	116	179	9.1
Gross outlays	212	317	469	8.3
Premium Receipts	-20	-26	-32	4.8
Net outlays	192	292	436	8.6

SOURCE: Congressional Budget Office.

ers. SMI benefits are financed primarily from general revenues, with beneficiaries paying a premium to cover some of the costs. SMI premiums are set in statute at 25 percent of SMI costs through 1998 and are currently $43.80 a month.

Beneficiaries usually incur health care expenses in addition to their SMI premium. Both HI and SMI require cost sharing in the form of deductibles and coinsurance. In addition, many beneficiaries face costs for services that Medicare does not cover, such as prescription drugs, physical examinations, hearing aids, dental care, and custodial care.

Most beneficiaries have a choice of traditional fee-for-service Medicare or health plans that are paid a fixed amount per enrollee, referred to as risk-based plans. Traditional fee-for-service Medicare pays separately for each specific service provided to beneficiaries. As a result, providers have a financial incentive to increase the use of services. Beneficiaries in turn have little financial reason to refuse services that may be of

Table 5-2.
Projections of Medicare Benefits by Type of Service (By selected fiscal year)

	Outlays (Billions of dollars)			Average Annual Rate of Growth, 1997-2007 (Percent)
	1997	2002	2007	
Fee-for-Service				
Hospital Insurance				
Inpatient hospital	87	105	125	3.7
Skilled nursing facility	13	19	27	7.6
Home health	19	30	43	8.6
Hospice	2	3	4	5.7
Subtotal	121	156	198	5.1
Supplementary Medical Insurance				
Physician[a]	31	35	39	2.5
Outpatient hospital and other services[b]	18	27	38	7.8
Laboratory services, durable medical equipment, and other services[c]	13	21	34	10.0
Subtotal	62	83	111	6.1
All Fee-for-Service Benefits	182	239	310	5.4
Health Maintenance Organizations	26	73	153	19.6
All Medicare Benefits	208	312	463	8.3

SOURCE: Congressional Budget Office.

a. Includes payments by carriers to physicians and nonphysicians under the physician fee schedule.

b. Includes outpatient hospital services, laboratory services in hospital outpatient departments, hospital-provided ambulance services, and other services paid by intermediaries.

c. Includes independent and physician in-office laboratory services, durable medical equipment, ambulance services paid by carriers, and other services paid by carriers.

some value, since they pay only a fraction of the cost of those services.

Moreover, most beneficiaries in the fee-for-service sector have some form of supplemental insurance that covers Medicare's cost-sharing requirements, making those requirements largely ineffective in discouraging the use of services. That supplemental insurance could be private ("medigap") coverage, employer-sponsored coverage for retirees, or Medicaid (for low-income beneficiaries).

In contrast, risk-based plans, primarily health maintenance organizations (HMOs) under current law, agree to provide Medicare-covered services to each enrollee for a fixed monthly payment. A plan paid on that basis is "at risk," since it is responsible for the full costs of care for its enrollees and thus has an incentive to provide that care in an efficient manner. Risk-based HMOs typically cover all or part of Medicare's cost-sharing requirements and may provide additional services as well.

CBO projects that the number of Medicare beneficiaries enrolled in risk-based plans will rise from 12 percent in 1997 to 34 percent by 2007 under current law. Because of that shift, enrollment in the traditional fee-for-service sector is projected to decline by 5 million people over the next 10 years. Even so, Medicare's payments to fee-for-service providers of home health care, skilled nursing care, and outpatient hospital services are still projected to grow about 8 percent to 9 percent a year--almost twice as fast as the economy (see Table 5-2).

Competing Goals

The rapid increase in Medicare spending projected over the next 10 years continues a pattern of growth that has long outpaced the growth of both the overall federal budget and the economy (see Table 5-3). Slowing that acceleration in Medicare spending has consequently been a long-standing focus of policy, and it is generally recognized that substantial Medicare savings would be required to achieve a balanced budget in 2002. Achieving budgetary balance may not, however, resolve the impending depletion of Medicare's HI trust fund.

Delaying Depletion of the HI Trust Fund

Revenues for the HI trust fund come from a 2.9 percent payroll tax on all wage and salary income, plus a small amount from income taxes levied on the Social Security benefits of upper-income recipients and from other sources. Since those revenues are limited, the trust fund can become depleted if outlays exceed income over a period of time. The Medicare trustees have

Table 5-3.
Medicare Spending Compared with Total Federal Outlays and the Economy (By selected fiscal year)

	Outlays (Billions of dollars)				Average Annual Rate of Growth (Percent)		
	1980	1990	1997	2007	1980-1990	1990-1997	1997-2007
Medicare Mandatory Outlays[a]	34	107	209	464	12.2	10.0	8.3
Total Federal Outlays	591	1,253	1,632	2,611	7.8	3.8	4.8
Gross Domestic Product	2,719	5,683	7,829	12,379	7.7	4.7	4.7

SOURCE: Congressional Budget Office.

a. Includes benefits plus mandatory outlays for administration.

Table 5-4.
Medicare Enrollment and Workers per Enrollee (By selected calendar year)

	1975	1985	1995	2005	2010	2030
Enrollment (Millions)	24.2	30.2	37.1	42.5	46.7	75.1
Workers per Enrollee	4.1	4.0	3.8	3.6	3.4	2.2
Average Annual Rate of Growth in Enrollment from Preceding Year Shown (Percent)		2.2	2.1	1.4	1.9	2.4

SOURCE: Congressional Budget Office and Medicare Board of Trustees (using the intermediate assumptions).

voiced concerns about the solvency of the HI trust fund for some years, and the fund fell into deficit in 1995. According to CBO projections and those of the trustees, the HI trust fund will be depleted in 2001 under current law.[1]

In contrast, the SMI trust fund receives income from premiums paid by beneficiaries and from general revenues. Since general revenue financing is uncapped, the SMI trust fund cannot be depleted, and it generally carries a small surplus. Because SMI outlays are likely to continue growing faster than premiums or general revenues, however, SMI is no more financially sound than HI.

Depletion of the HI trust fund could be delayed through policies that would also contribute to the overall goal of deficit reduction. Such policies would either reduce the growth in spending for Medicare-covered services or increase federal revenues, a part of which could be earmarked for the HI trust fund. Reducing payments to hospitals, skilled nursing facilities (SNFs), home health agencies, and other providers of HI services, for example, would reduce federal spending, as would requiring beneficiaries to pay a larger share of the costs for HI services. Raising the HI payroll tax would also contribute to the solvency of the trust fund and add to the overall level of federal revenues.

Other policies could delay depletion of the trust fund without reducing the federal budget deficit. Shifting services out of HI, as proposed recently for certain home health services, is one such policy. Depletion of the trust fund could be avoided indefinitely by transferring general revenues to it as necessary, as is now done for the SMI trust fund. Unless sources of additional funds were identified, however, such an approach would do nothing to shrink the deficit.

Restructuring Medicare

Recent concerns about the financing of Medicare, including the impending depletion of the HI trust fund, reflect the continuing rise of Medicare spending per beneficiary rather than exceptional growth in the number of beneficiaries. Indeed, that population is now growing at a historically slow rate (see Table 5-4). The relatively small cohort of Depression-era babies retiring over the next decade, coupled with the large number of baby boomers who are in their prime earning years, provides very favorable circumstances for financing Medicare and, in particular, the HI trust fund.

Enrollment in Medicare will, however, increase dramatically as the baby boomers reach age 65. Between 2010 and 2030, enrollment is projected to grow by 2.4 percent a year, up from the 1.4 percent average annual

1. Medicare Board of Trustees, *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (June 1996). The board projects a depletion date of 2001 under both its intermediate- and high-cost assumptions. Even under its low-cost assumption, the board projects a depletion date of 2002.

Box 5-1.
Medicare as a Defined Contribution Plan

Policy options for Medicare that might be implemented in the near term would retain both a traditional fee-for-service sector and risk-based plans. Consequently, the traditional fee-for-service sector, with its open-ended claim on federal payments, would continue to drive the growth of Medicare spending. A more ambitious option would provide a fixed payment for every beneficiary--in effect, converting the entire Medicare program to a defined contribution plan.

Under that option, beneficiaries could enroll in any health plan, including fee-for-service plans, with Medicare's contribution set at a fixed amount per beneficiary. Beneficiaries who chose lower-cost plans might pay no more than they do now, but each beneficiary would be liable for the full additional cost of selecting a plan that cost more than Medicare's payment. Those enrolling in fee-for-service plans might be required to pay such a surcharge under a defined contribution program.

A defined contribution plan that eliminated the special status of Medicare's fee-for-service sector would be practical only if beneficiaries had more than one plan from which to choose. Oversight might be needed to ensure that each health plan met an acceptable level of quality and services. But the federal government's experience in running a successful health insurance program for its employees based on the principles of a defined contribution plan could be useful in establishing the mechanics of such a system for Medicare.

Whether a defined contribution option can slow the growth of Medicare spending to sustainable long-term rates and provide adequate health coverage for a growing number of beneficiaries depends on how well competition among health plans fosters efficiency. A restructuring of the program that is poorly designed could fail to meet those policy goals. Nonetheless, a market-based strategy may be the most promising approach to resolving the problem of financing Medicare in the long term.

growth projected through 2007. By 2030, Medicare enrollment will have doubled, to 75 million people.

The increase in Medicare enrollment caused by the aging of the population will be accompanied by a tapering of the growth rate of the working-age population. The number of workers will drop from 3.8 for every Medicare beneficiary in 1997 to 2.2 per beneficiary by 2030. Consequently, demographic trends will drive up the demand for Medicare services after 2010, at the same time that the workforce that provides the bulk of Medicare's financing will be growing relatively slowly.

In contrast to those demographic trends, Medicare spending per beneficiary has risen rapidly in recent years, and that pattern is expected to continue. Between 1997 and 2007, for example, CBO projects that Medicare spending per beneficiary will increase 6.8 percent a year under current law.

It is difficult to project growth in Medicare spending per beneficiary over the long term. The Medicare trustees assume that the growth in that spending will gradually slow between 2005 and 2020 and be more in line with growth in national income per capita. Even under that assumption, however, CBO projects that federal spending on Medicare will overtake spending on Social Security within 30 years.[2]

Recent proposals would pursue a market-based strategy to slow the long-term growth of Medicare spending. Such a strategy could lead ultimately to a more competitive Medicare market, with health plans competing for enrollees on the basis of lower costs and higher quality of care. But to achieve that result, beneficiaries would need incentives to choose lower-cost plans, and the growth in Medicare's contributions to premiums would have to be limited. Having Medicare make a fixed payment on behalf of each beneficiary that was no greater than the price of a low-cost plan, as in a defined contribution plan, would produce such incentives. Beneficiaries choosing to enroll in more expen-

2. See Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options* (forthcoming).

sive plans would have to pay the difference themselves (see Box 5-1).

Establishing a more competitive market for Medicare would require substantial redesign of the program. New methods would be needed to determine the federal payment to health plans, since that payment would no longer depend on the amount of services provided to each enrollee. Payments would have to be adjusted both to ensure that health plans had a financial incentive to enroll people who were less healthy and to avoid overpaying plans that attracted a mix of patients that was less costly than average. Provisions might also be necessary to ensure that patients would not be denied appropriate services. To minimize disruptions in the existing relationships between beneficiaries and their providers, a defined contribution plan could be phased in by requiring only new Medicare enrollees to participate each year and allowing older beneficiaries to shift voluntarily to the new system.

Although a complete restructuring of Medicare could require years of development, practical steps to begin that process could be adopted now. Policy options that foster program restructuring and cost containment could also contribute to the short-term goals of reducing the deficit and improving the solvency of the HI trust fund.

Options to Contain Medicare Costs in the Near Term

Policy goals for the near term--meeting deficit reduction targets for Medicare over the next five years and delaying depletion of the HI trust fund for several years beyond 2001--could be met in a variety of ways (see Box 5-2). Some options would limit program spending by reducing the growth of payments to providers, for example, or by increasing the costs imposed on beneficiaries. Some of those options would also provide a basis for the fundamental restructuring of the program that would prepare Medicare to meet unprecedented demands for health care when the baby-boom generation reaches age 65.

Constrain Costs in Fee-for-Service Medicare

Efforts to constrain costs in Medicare's fee-for-service sector have traditionally focused on limiting growth in the prices of services. Policies that limit prices do not change the incentive for providers to offer more services, however, and may not effectively curb the growth in expenditures, which represent price times volume of services. Introducing payment systems that limit spending, rather than prices, could be a more effective strategy for the long term.

Lower Annual Updates to Existing Payment Systems. The Health Care Financing Administration periodically adjusts Medicare's fee-for-service payments to reflect inflation or cost increases as required by statute. But the Congress has frequently enacted policies that adjust payment rates by less than the increases in the relevant indexes of inflation. Lowering the annual updates is easy to do, but that approach accepts the sometimes perverse incentives that existing payment systems have created.

Not all of the savings that could be gained by slowing the growth of those annual updates would be realized. Providers would be able to offset part of their potential loss in Medicare receipts by increasing the volume of services they provide to beneficiaries or by providing more services of a complex nature that earn higher Medicare payments. Such a response to the policy could offset as much as half of the potential savings from lowering the update.

Furthermore, if payment rates were too tightly limited, beneficiaries could encounter difficulties getting care from some providers or might not be able to obtain certain services. Yet even a sizable cut in payment updates might not lead to such problems if private insurers were also trimming rate increases. In that case, providers would not have better-paying alternatives to Medicare and would be unlikely to turn away Medicare business.

Institute New Payment Methods. Alternative payment methods may provide explicit incentives within a fee-for-service environment to control the volume and

complexity of services--the prospective payment system (PPS) for inpatient hospital services being the preeminent example. That system pays a fixed amount for treatment delivered during an episode of care (defined as all services furnished during an inpatient stay) rather than for each service individually.

Prospective payment systems could be expanded to other services, such as those delivered through hospital outpatient departments, skilled nursing facilities, and home health agencies. But developing such payment systems could be a lengthy and difficult process. Cost savings would depend on how the systems were designed. For example, more savings would be likely if episodes for which payment was made were defined broadly, to encompass more fully the care needed to treat the patient's illness. A broad definition would limit the provider's opportunity to shift necessary services outside the defined episode and then be paid on an individual fee-for-service basis.

There are several general approaches that could spur greater efficiency in the fee-for-service sector. An approach that has been successfully used to limit the growth of payments to physicians is to impose so-called volume performance standards. Those standards estab-

Box 5-2.
Options to Reduce Growth in Medicare Spending

A variety of specific policy options could reduce the growth of Medicare spending over the 1998-2002 period and beyond. Those options would constrain costs in fee-for-service Medicare, increase the amount beneficiaries pay for their own care, or increase savings from risk-based plans. The following policy options, discussed in more detail in subsequent sections of the chapter, could be included in a comprehensive Medicare proposal.

Constrain Costs in Fee-for-Service Medicare

Options to slow the growth of fee-for-service spending would set payment rates based on current payment methods or establish new payment methods that could spur greater efficiency in the fee-for-service sector. Specific options include:

- Lowering annual updates for payments;
- Instituting new payment methods, such as prospective payment, volume performance standards, bundling, and competitive bidding.

Increase the Financial Responsibility of Beneficiaries

Medicare spending could also be reduced by imposing more costs on beneficiaries. Specific options include:

- Raising premiums through an across-the-board increase or by tying premiums to income;
- Increasing cost sharing by using deductibles and copayments;
- Restructuring supplemental insurance.

Increase Savings from Risk-Based Plans

The current method of paying risk-based plans could be altered to increase Medicare's savings. Specific options include:

- Lowering payment rates to below 95 percent of the fee-for-service rate;
- Instituting new payment methods, such as breaking the link with costs in the fee-for-service sector or using competitive bidding.

Potential savings from improved payment methods could be enhanced by taking steps to increase enrollment in risk-based plans. Specific options include:

- Lowering fee-for-service spending;
- Expanding the range of eligible plans;
- Overhauling enrollment procedures;
- Permitting cash rebates;
- Reducing disparities in Medicare payments to plans in different localities.

lish an acceptable rate of growth of Medicare payments for particular services. If the growth in payments for specific services exceeded the standard, the following year's payment update would be lowered.

Broadening the scope of payment so that a single payment accounts for a number of related services would also improve incentives for fee-for-service providers. Bundling the payment for post-acute care services, such as those provided by a skilled nursing facility and home health agency following an inpatient stay, into the hospital PPS would reduce the hospital's incentive to discharge patients too quickly into post-acute care. An alternative to broadening payment definitions would be to shift from administered pricing for services to more market-oriented methods. Medicare could take advantage of its buying power to establish lower payment rates through competitive bidding, for example, or by negotiating services with provider groups. But substantial development would be required before Medicare could adopt either bundled payments or market-based pricing methods.

Increase the Financial Responsibility of Beneficiaries

Imposing additional program costs on beneficiaries through higher cost-sharing requirements and premiums would produce program savings. In principle, increasing what beneficiaries must pay when they receive health services provides an incentive to limit their use of those services, whereas raising premiums does not. But widespread private and public supplemental coverage has dampened those incentives. Restructuring the supplemental insurance market could restore the responsiveness of beneficiaries to costs in fee-for-service Medicare.

Raise Premiums. SMI premiums are set in statute at 25 percent of SMI costs but only through 1998. After that, growth in premiums is limited to the rate of increase of Social Security cash benefits. As a result, SMI premium income is projected under current law to decline significantly as a percentage of SMI costs. Increasing the premium as a percentage of costs would clearly generate program savings. Even freezing the premium at its current share of costs would provide some future savings.

A premium increase could be carried out in several ways. The simplest would uniformly raise the SMI premium for all beneficiaries. Beneficiaries who are eligible for Medicaid would be protected from such an increase under current law.[3] Both state and federal governments would share the additional Medicaid costs for those people. But such an approach could impose financial hardship on some low-income beneficiaries who are not also eligible for Medicaid.

Premiums could instead be set to increase with the income of beneficiaries, rising to equal the full cost of SMI for upper-income beneficiaries. The potential for savings from an income-related premium is limited, however, since most beneficiaries have modest income. Large savings could be obtained only by setting the income thresholds for additional premiums at low levels.

Increase Cost Sharing. Medicare has a complex structure of deductible and coinsurance requirements that vary by type of service. For example, the inpatient deductible is $756 in 1997, and hospital stays of more than 60 days require a substantial copayment. Care in SNFs is subject to copayments of $94.50 a day after the first 20 days. Most services covered by SMI are subject to a $100 deductible, after which the patient is responsible for 20 percent of covered expenses (as well as any additional amount that the physician is allowed to charge). Home health care, in contrast, is not subject to any cost-sharing requirement.

Simply raising Medicare's cost-sharing requirements, however, would retain this complicated structure. Cost sharing could be extended to home health services, for example, or the SMI deductible could be raised to a level similar to deductibles under most employer-sponsored health plans. Any increase in cost sharing for HI services would contribute to the solvency of the HI trust fund, but such increases for hospital or SNF care might be unreasonable.

3. All Medicare beneficiaries with income of less than 120 percent of poverty are now eligible to have Medicaid pay their Supplementary Medical Insurance premium. All of those with income of less than 100 percent of poverty are eligible for coverage of Medicare's cost-sharing requirements as well, and some are eligible for additional Medicaid benefits.

Simplifying Medicare's cost sharing would provide an opportunity to increase those requirements while shifting some of the financial burden away from patients needing the most care. The cost-sharing requirements for inpatient hospital services have been widely criticized for the potentially heavy burden they place on that group of patients, but the modest SMI deductible, which most beneficiaries pay regardless of their health status, could be raised. Private health plans generally have a single annual deductible and uniform coinsurance for services rendered by hospitals, physicians, and other providers. Medicare could streamline its cost-sharing requirements in a similar way. As with premium increases, some of the savings from higher cost sharing would be offset by increased Medicaid outlays.

Restructure Supplemental Insurance. Almost three-quarters of beneficiaries in fee-for-service Medicare have supplemental coverage through private medigap insurance, health plans for retirees, or Medicaid. That coverage typically pays for Medicare's cost-sharing requirements, reducing the incentives for beneficiaries to curb their use of services. Medigap premiums would, however, increase to reflect any additional cost sharing. Greater cost sharing could persuade some beneficiaries to enroll in risk-based managed care plans to avoid higher out-of-pocket costs in the fee-for-service sector.

Nonetheless, without a major change in the supplemental insurance market, greater cost-sharing requirements would be unlikely to induce most beneficiaries to use fewer services. One approach would prohibit supplemental policies from covering Medicare cost sharing. That option would, however, be extremely unpopular with most beneficiaries, who are averse to the risk of unexpected health costs.

Other approaches could be implemented as part of a broader reform of Medicare. For example, if Medicare was organized into a system of competing health plans, those plans could be allowed to offer supplemental coverage only to their own enrollees. In that way, the costs of increased use of services that might result from the additional coverage would be confined to the plan itself, just as risk-based HMOs currently accept the financial consequences of any additional benefits they offer their enrollees.

Increase Savings from Risk-Based Plans

The strong growth in enrollment in risk-based plans that CBO projects over the next decade is driven by two factors. First, an increasing proportion of people becoming eligible for Medicare at age 65 will already be HMO members, making Medicare's HMO sector more familiar. Second, Medicare HMOs will become relatively more attractive to beneficiaries as the cost of medigap coverage in the fee-for-service sector continues to rise.

The shift in enrollment toward risk-based HMOs would not slow Medicare spending unless improvements were made in the payment method so that the program could retain some of the savings that managed care plans would generate. Greater program savings could, however, reduce the attractiveness of HMOs to beneficiaries because HMOs would be less likely to offer the array of additional benefits that most of them currently offer. Some plans might be discouraged from participating in the risk-based Medicare sector at all. Consequently, options that could encourage enrollment in risk-based plans, even as those plans became less generous, should be considered.

Set Payment Rates. Medicare pays a fixed amount for each enrollee in risk-based HMOs equal to 95 percent of fee-for-service costs in each local area, adjusted for demographic and other characteristics of the plans' enrollees. Plans that are paid a fixed amount per beneficiary have an incentive to enroll relatively healthy beneficiaries, who use fewer services on average. Because Medicare's current payment formula does not fully account for that "favorable selection" of enrollees, the federal government pays a little more for typical enrollees in risk-based plans than those enrollees would have cost in the fee-for-service sector (see Box 5-3).

Even if adjustments for favorable selection remained crude, payment levels could be set to lower overall Medicare spending. Doing so, however, could erode the incentives for both health plans and beneficiaries to participate in Medicare's risk-based program.

The simplest alternative would change Medicare's payment rate from 95 percent of fee-for-service costs to some lower percentage. That option might yield savings but would do nothing to correct for any favorable selection in the program. Moreover, the growth of spending in the risk-based program would still continue to be tied to costs in the fee-for-service sector.

Breaking the link between costs in the fee-for-service sector and payments to risk-based plans would prune some of the inflation built into the current payment system and produce program savings. One option would be to set the rate of growth of risk-based payments equal to an external factor, such as the growth rate of the overall economy. Such an indexing method would allow spending in the risk-based program to grow only as quickly as the country's overall ability to pay for it. Total Medicare spending would continue to grow faster than the economy, however, unless additional steps were taken to limit spending in the traditional fee-for-service sector.

Arbitrarily limiting the growth rate of payments to risk-based plans could lead to inefficiency, with some plans being compensated too generously and other plans too poorly (and ultimately dropping out of Medicare's risk-based sector). To avoid such problems, Medicare could adopt competitive bidding and other alternatives to administered pricing that would tie payment rates more directly to market conditions. But bidding would work only in areas having a number of Medicare risk-based plans. Moreover, although research on alternative pricing methods has been undertaken, Medicare as yet has no operating experience with such methods.

Encourage Enrollment. Reducing the growth of payments to risk-based plans could lead to savings for Medicare. But that reduction would probably make the Medicare program less attractive for such plans and reduce the attractiveness to beneficiaries in the risk-based HMOs that chose to remain in Medicare. The profit margins of the plans would be squeezed, and their ability to offer benefits beyond the basic Medicare package would be reduced.

The savings from reducing Medicare payments to risk-based plans depend on how enrollment might be affected. Options that could make the risk-based program more attractive to health plans and beneficiaries include:

- *Establishing policies to lower fee-for-service spending in Medicare.* That action would reduce payments to providers or increase costs to beneficiaries in fee-for-service Medicare. If payments to risk-based plans were not linked to costs in the fee-for-service sector, such an approach would increase the attractiveness of risk-based payment. Providers, and in particular physicians, might respond by shifting their practices to risk-based plans. Beneficiaries might then follow their physicians to the new plans, especially if they also faced higher out-of-pocket costs in the fee-for-service sector.

Box 5-3.
Adjusting Payments for Favorable Selection

Medicare's current payment system for risk-based managed care plans is, by design, unrelated to the plans' cost of doing business. Instead, payment rates are tied to the cost of providing services in the fee-for-service sector, adjusted for the enrollee's age, sex, disability status, institutional status, Medicaid eligibility, and work status.

Those adjustments for health risk are crude, however, and do not completely account for variations in the cost of providing health care to people within the categories of payment. Risk-based plans have an incentive to market selectively to relatively healthy enrollees within each payment category, although the extent to which they actually do so is debatable. Moreover, relatively healthy beneficiaries may be more likely to enroll in such plans, since they typically do not have strong ties to a fee-for-service provider. Because the current payment formula does not adjust adequately for that favorable selection, Medicare does not share in the savings from more efficient managed care plans.

Forging better methods for adjusting payments to reflect the health status of enrollees and their use of services could improve Medicare's ability to realize program savings from managed care plans. Developing risk-adjustment methods is technically complex, however. Indeed, the past decade of research has failed to identify substantial improvements in those methods.

- *Expanding the array of risk-based plans to include a range of managed care and private fee-for-service options.* Beneficiaries would be better able to find plans meeting their preferences if the range of options was expanded, although doing so would also increase the possibilities for favorable selection. Offering a wider variety of plans could, moreover, raise a variety of regulatory issues, such as solvency requirements for new types of health plans, standards for quality of care, and antitrust considerations. The Health Care Financing Administration is conducting demonstration projects to explore the implications of expanding the range of risk-based plans.

- *Overhauling Medicare's enrollment procedures.* Although beneficiaries are given a list of risk-based plans operating in their local area, they may have difficulty choosing among them because no single source of information compares the features of the plans. Moreover, most beneficiaries are automatically enrolled in fee-for-service Medicare on first gaining eligibility; only later can they enroll in a risk-based plan. Only new enrollees who are already in a Medicare-certified plan may continue in that plan in a seamless fashion. One option would be to institute a coordinated open-enrollment process similar to that of the Federal Employees Health Benefits program, with beneficiaries selecting from all health plans operating in their area. Beneficiaries would receive information on all plans regarding costs, access to providers, additional benefits that might be available, and other factors.

- *Allowing risk-based plans to offer beneficiaries cash rebates as well as extra benefits.* Risk-based plans now compete only on the basis of coverage and quality of services. Plans could also compete for enrollment on the basis of price under this option. Plans would be less likely, however, to offer cash rebates or extra benefits if payment rates were limited.

- *Reducing the wide disparities in Medicare payments to risk-based plans in different localities.* Plans in areas having below-average payment levels could, for example, be given higher annual payment updates, which could encourage more plans in those areas to participate in Medicare. If plans in high-payment areas receiving smaller-than-expected updates reduced the generosity of their coverage, however, those plans could lose enrollment.

Illustrative Budget Packages

Medicare options can be combined in numerous ways to form an integrated budget package. Packages offering a particular level of savings over the next five years can be more or less successful in achieving longer-term goals, including delaying the depletion of the HI trust fund. That success depends on the specific combination of options that would reduce payments to providers, increase beneficiaries' costs, increase program revenues, or more fundamentally restructure Medicare.

The following discussion covers how policy options might be combined to meet two alternative savings targets: $100 billion and $150 billion in Medicare savings between 1998 and 2002. To provide some insight into the effects of each of the budget packages over a longer time period, savings and trust fund balances are also projected through 2007, assuming that the specified policies remain in effect for 10 years.

The budget packages are illustrative and do not include all of the specific policies that might be part of a full budget proposal. For example, the fee-for-service options presented below would reduce payment updates. More complex policies that would introduce prospective payment or bundling methods or otherwise alter the way Medicare covers services are not specifically discussed. This simplified presentation focuses on the overall impact of policies on providers and beneficiaries and does not imply a judgment about the appropriateness of any specific option.

Reduced payments for benefits in the fee-for-service sector account for most of the savings from the illustrative budget packages, reflecting the high proportion of Medicare spending on those benefits over the next five to 10 years. Benefits in the fee-for-service sector account for over 80 percent of the projected $1.2 trillion cumulative outlays net of premiums for Medicare benefits between 1998 and 2002 (see Table 5-5). Even if aggressive policies were adopted to increase savings from and enrollment in risk-based plans, the fee-for-service sector would probably continue to domi-

nate the Medicare program in the near term unless a more thorough restructuring was undertaken.

Five-Year Savings Target: $100 Billion

The illustrative policy package that would produce savings of $100 billion over the next five years includes options that would lower payment updates in the fee-for-service sector, break the link between fee-for-service costs and payments to risk-based plans, and freeze SMI premiums at 25 percent of SMI costs. That policy package would save a total of $99 billion between 1998 and 2002, and $448.6 billion through 2007 (see Table 5-6).

Savings from Fee-for-Service. Most of the savings over the next five years in the first budget package would come from lowering the growth of payments to fee-for-service providers--$67.6 billion between 1998 and 2002. Over 10 years, however, enrollment in that sector would decline, and the resulting savings would

Table 5-5.
Budgetary Impact of Illustrative Medicare Packages, 1998-2002 (In billions of dollars)

	Five-Year Cumulative Total	
	$100 Billion Package	$150 Billion Package
Current Law		
Fee-for-Service Benefits	1,077.1	1,077.1
HMO Payments[a]	264.4	264.4
Total Premium Receipts[b]	-117.4	-117.4
Total	1,224.1	1,224.1
Changes in Outlays		
Fee-for-Service Reductions	-67.6	-89.8
Risk-Based Plan Savings	-26.1	-32.9
SMI Premium Increases[c]	-5.3	-28.9
Total	-99.0	-151.6
Post-Policy		
Fee-for-Service Benefits	1,009.5	987.3
HMO Payments[a]	238.3	231.6
Total Premium Receipts[b]	-122.7	-146.3
Total	1,125.1	1,072.6

SOURCE: Congressional Budget Office.

NOTE: HMO = health maintenance organization; SMI = Supplementary Medical Insurance.

a. Includes health plans paid on a risk basis and plans paid on a cost-reimbursement basis.

b. Includes Hospital Insurance and SMI premiums.

c. Policies would increase SMI premiums only. Premium increases are shown net of interactions with Medicaid.

account for a little more than half of the total--$249 billion through 2007. The options described below represent only some of the specific policies that could be enacted to meet the savings target.

HI savings derive from reductions in payments to hospitals, SNFs, and home health agencies. Updates to hospital payments would be reduced by 2.5 percentage points each year. That reduction would apply to hospitals paid under the prospective payment system and those paid on a cost basis; it would affect payments for capital and operating expenses. Capital payments would be further reduced in 1998 to eliminate the effect of the 1996 increase in capital payment rates.

Routine services provided in skilled nursing facilities are paid on a cost basis subject to per-day limits; those limits would be lowered. In addition, ancillary services would be paid on a per-day basis rather than on a per-service basis, and the growth in payment amounts would be limited. Capital payments to SNFs would also be reduced by 10 percent.

Home health services are paid on a cost basis subject to limits on aggregate agency expenditures. Those limits would be reduced, and new limits would be placed on the amount of spending allowed during a year for users of home health services. This illustrative budget package does not include the transfer of home health services from HI to SMI.

SMI savings would be achieved by reducing annual payment updates for services provided by physicians, clinical laboratories, and ambulatory surgery centers, as well as for durable medical equipment and other items. Fees would be set so that overall spending for physicians' services would grow by 1 percentage point less than the growth in real (inflation-adjusted) gross domestic product (GDP) per capita. Increases in payments for clinical laboratory services, durable medical equipment, and other items would also be curtailed.

Numerous combinations of policies could generate similar savings. The choice of specific policies would determine how the reduction in payments was distrib-

Table 5-6.
Illustrative Policy Package to Meet a Savings Target of $100 Billion, 1998-2002 (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	Cumulative Savings 1998-2002	Cumulative Savings 1998-2007
Reduction in Payments to Providers in Traditional Medicare							
Hospital[a]	2.2	4.2	6.2	8.1	10.2	30.8	117.4
Skilled nursing facility	1.2	1.7	2.8	3.2	3.6	12.6	37.6
Home health	0	1.7	2.3	2.8	4.7	11.5	47.4
Physician	0.1	1.2	2.1	2.9	3.5	9.8	32.0
Other services	0.1	0.3	0.5	0.8	1.1	2.9	14.5
Subtotal	3.7	9.1	13.9	17.8	23.1	67.6	249.0
Risk-Based Health Plans	1.0	2.8	5.4	6.7	10.3	26.1	162.5
SMI Premium Revenue[b]	-0.2	0.4	1.0	1.6	2.4	5.3	37.1
Total Medicare Savings	4.4	12.3	20.3	26.1	35.8	99.0	448.6

SOURCE: Congressional Budget Office.

NOTE: SMI = Supplementary Medical Insurance.

a. Includes impact of program savings on Hospital Insurance premiums.

b. Basic SMI premium equal to 25 percent of SMI costs, extended beyond 1998.

uted within a provider group (for example, between urban and rural hospitals, or between surgical and medical physician specialties), among provider groups (for example, between hospitals and physicians), and between the HI and SMI trust funds. If reductions in payments to one provider group were considered too austere, the savings target could be achieved by offsetting smaller reductions in payments to that group with greater cuts in updates for other providers.

CBO calculated the reductions in hospital spending, for example, by lowering payment updates for the operating and capital costs of PPS hospitals and PPS-exempt hospitals by 2.5 percentage points below the hospital market basket (an index of hospital input costs used to update payments). Instead of making that across-the-board reduction, one could also achieve savings by altering the incidence of update reductions among the different types of payments. Reductions from current-law payment levels could also be made in other payments to hospitals, including payments for graduate medical education and disproportionate share payments to hospitals serving a high percentage of low-income people.

Savings from Risk-Based Plans. The link between fee-for-service costs and payments to risk-based plans would be broken under the $100 billion savings package. Payments to risk-based plans would be updated each year by growth in GDP minus 1 percentage point. To maintain enrollment in those plans under a more stringent payment policy, the scope of Medicare's risk-based program would be expanded to include a broader array of plans, and the enrollment process would be improved. Those changes are assumed to maintain enrollment in risk-based plans at baseline levels. The payment and enrollment policies would together yield $26.1 billion in savings between 1998 and 2002, and $162.5 billion through 2007.

Premiums. Under current law, the SMI premium will remain at 25 percent of costs through 1998 and then decline. The $100 billion savings package would extend the 25 percent rule beyond 1998, yielding $5.3 billion in program savings between 1998 and 2002. That policy would generate $37.1 billion in savings through 2007.

CBO projects that the monthly premium under the $100 billion savings package would drop by 50 cents in 1998 compared with current law (see Table 5-7). That drop in the premium is the result of proposed reductions in SMI outlays that would not be offset by any increase from current law in calculating the premium. After 1998, the monthly premium would rise faster than under current law. By 2002, the premium would reach $58.10, or $6.60 a month more than it would have been without legislation. By 2007, the premium would be $83.10, or $23.40 a month more than it would have been under current law.

Table 5-7.
Projections of Monthly Premiums for Supplementary Medical Insurance (By selected calendar year, in dollars)

	1997	1998	2002	2007
Current Law	43.80	45.80	51.50	59.70
$100 Billion Savings Package	43.80	45.30	58.10	83.10
$150 Billion Savings Package				
Basic	43.80	48.80	68.80	93.80
Tied to beneficiaries' income (Maximum)	n.a.	179.40	224.10	314.00

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

Status of the Trust Fund. Outlays from the HI trust fund have exceeded receipts since 1995, resulting in a decline in the trust fund's balance. CBO projects that under current law, HI outlays will continue to outpace income, and the trust fund will be exhausted in 2001. By 2007, outlays will exceed receipts by $130 billion, and the trust fund will have a negative balance of $556 billion (see Table 5-8).

Even if the policies in this budget package were continued for 10 years, the resulting reductions in HI outlays would help to stem, but not eliminate, the net outflow of funds over the next decade. The 10-year savings total of $448.6 billion would be split between HI and SMI, with $202.4 billion coming from reductions in spending on HI services (see Table 5-6). According to CBO projections, the trust fund would be depleted in 2003 under this budget package.

The five-year savings target of $100 billion could be met in other ways that would keep the HI trust fund solvent through 2007. But to achieve that result, nearly all the savings would have to come from HI. Alternatives that assume a steady reduction in spending or an increase in payroll taxes illustrate this point, including:

- *Reducing the rate of growth of HI outlays by 4.3 percentage points each year, beginning in 1998.* The growth rate between 1997 and 2007 would drop from 7.7 percent a year under current law to 3.5 percent. HI outlays would be reduced by about $103 billion between 1998 and 2002, and nearly $460 billion between 1998 and 2007.

- *Delaying the reduction in HI outlays until 1999 and reducing the rate of growth of outlays by 5.3 percentage points each year thereafter.* By delaying a year, the growth rate of HI outlays could average only 3.2 percent a year between 1997 and 2007 if the trust fund was to maintain a positive balance through 2007. HI outlays would fall by about $88 billion between 1998 and 2002, and by nearly $470

Table 5-8.
Status of the Hospital Insurance Trust Fund, 1998-2002 and 2007 (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2007
Current Law						
Income	131	136	140	144	147	160
Outlays	149	161	177	185	202	290
Surplus	-18	-25	-36	-41	-54	-130
End-of-year balance	98	73	37	-5	-59	-556
$100 Billion Savings Package						
Income	131	136	142	146	152	180
Outlays	144	151	161	165	175	220
Surplus	-13	-15	-19	-19	-23	-40
End-of-year balance	102	88	68	50	26	-152
$150 Billion Savings Package						
Income	131	137	142	147	153	186
Outlays	143	149	157	160	168	201
Surplus	-12	-12	-15	-12	-15	-15
End-of-year balance	104	92	77	64	50	-41

SOURCE: Congressional Budget Office.

billion between 1998 and 2007. To compensate for the loss in HI savings resulting from delaying policy action, additional savings of $12 billion would have to come from SMI to meet the five-year deficit reduction target.

- *Raising the HI payroll tax rate from 2.9 percent to 3.8 percent of wage and salary income, beginning in 1998.* That tax increase would generate about $200 billion in additional revenues between 1998 and 2002, twice as much as would be needed to meet the five-year savings target. This option would yield about $450 billion in revenues between 1998 and 2007, which is the same magnitude of savings the other alternatives would generate over 10 years.

Keeping the HI trust fund solvent through 2007 would require such large spending cuts or payroll tax increases that the five-year deficit reduction target could be met with little or no reduction in outlays from SMI. If the policy goal was met solely through reductions in spending for HI services, those reductions would be quite stringent. Relying solely on tax increases would, however, do nothing to slow the growth of spending that threatens Medicare's stability over the long term.

Five-Year Savings Target: $150 Billion

Increasing the amount of Medicare savings to $150 billion over the next five years would require further reductions in payment updates to fee-for-service providers. This budget package would also scale back payments to risk-based plans by limiting their payment updates to the rate of growth of GDP minus 2 percentage points. To achieve additional savings, the monthly SMI premium would go up $5 every year, beginning in 1998. An additional premium linked to the amount of beneficiaries' income would also be imposed. Total Medicare savings between 1998 and 2002 would be $151.6 billion, and $645.5 billion through 2007 (see Table 5-9).

Savings from Fee-for-Service. Lower spending in the fee-for-service sector accounts for $89.8 billion in savings between 1998 and 2002, and $332.5 billion through 2007. The limits on payments to hospitals, physicians, and other providers of outpatient services are more stringent than those in the $100 billion savings package.

Payment updates for hospital services would face an across-the-board reduction of 4 percentage points from the hospital market basket, rather than the 2.5 percentage-point reduction under the other package. Fees would be set so that overall spending for physicians' services would grow by 2 percentage points less than the growth in real GDP per capita--a drop of 1 percentage point from the $100 billion savings package. Further reductions in payments for other outpatient services would also be instituted.

As discussed earlier, a different mix of policies could achieve the fee-for-service savings in this budget package. For example, savings from a slower growth in payments for SNF and home health services could be substituted for some of the additional hospital savings assumed here. However, the range of possibilities is more limited than under the first package, given the higher level of fee-for-service savings in this one.

Savings from Risk-Based Plans. Payments to risk-based plans under the $150 billion savings package would be updated to the rate of growth of GDP minus 2 percentage points. Although this is a stricter update policy than the one in the $100 billion package, this package assumes that additional actions are taken to maintain enrollment in risk-based plans at baseline levels. Those payment and enrollment policies would together yield $32.9 billion in savings between 1998 and 2002, and $203.8 billion through 2007.

Premiums. The $150 billion savings package contains two changes in premiums that together would boost revenues by $28.9 billion between 1998 and 2002, and $109.2 billion through 2007. Every beneficiary would face an increase of $5 in the basic monthly premium each year beginning in 1998, which would account for most of the new revenues.

An additional premium would be levied on individuals with annual income greater than $50,000 and couples with income greater than $75,000. (Income thresholds would not be indexed for inflation under this option.) The additional premium would rise with income. Consequently, the basic and additional premiums combined would reach a level equal to 100 percent of SMI costs for individuals with annual income of

$100,000 or more and couples with income of $150,000 or more. That income-related premium would yield $10.1 billion in additional revenues over the next five years, and $34.3 billion through 2007.

Under the $150 billion savings package, more than 90 percent of Medicare beneficiaries would pay only the basic premium of $48.80 a month in 1998. That basic premium would rise to $68.80 by 2002, an increase of $17.30 compared with current law (see Table 5-7). Less than 3 million beneficiaries in 1998 would pay an additional premium amount, although only about 500,000 would pay the maximum premium.

The larger basic premium under this budget package would raise the costs of state Medicaid programs, which pay the premiums and cost-sharing requirements for people who are eligible for both Medicare and Medicaid. CBO estimates that total Medicaid spending would increase by about $3 billion between 1998 and 2002 because of higher payments for Medicare premiums. Of that amount, about $1.3 billion would represent additional costs to the states.

Status of the Trust Fund. The more aggressive cost cutting called for under the $150 billion savings package would contribute only modestly to the solvency of the HI trust fund, extending the date of depletion to 2005.

Conclusions About Medicare

Rapid growth in Medicare spending has been a long-standing policy concern. In spite of major payment reforms instituted during the 1980s in fee-for-service Medicare and the introduction of risk-based HMOs,

Table 5-9.
Illustrative Policy Package to Meet a Savings Target of $150 Billion, 1998-2002 (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	Cumulative Savings 1998-2002	Cumulative Savings 1998-2007
Reduction in Payments to Providers in Traditional Medicare							
Hospital[a]	3.2	6.3	9.4	12.4	15.6	46.9	178.5
Skilled nursing facility	1.2	1.7	2.8	3.2	3.6	12.6	37.6
Home health	0.0	1.7	2.3	2.8	4.7	11.5	47.4
Physician	0.4	1.8	3.2	4.2	5.2	14.8	51.6
Other services	0.3	0.5	0.8	1.0	1.4	4.0	17.4
Subtotal	5.0	12.1	18.4	23.7	30.6	89.8	332.5
Risk-Based Health Plans	1.2	3.5	6.7	8.5	13.0	32.9	203.8
SMI Premium Revenue							
Basic premium[b]	0.9	2.3	3.7	5.2	6.7	18.8	75.0
Tied to beneficiaries' income	0.4	2.0	2.2	2.6	3.0	10.1	34.3
Subtotal	1.3	4.2	6.0	7.8	9.6	28.9	109.2
Total Medicare Savings	7.5	19.8	31.1	40.0	53.2	151.6	645.5

SOURCE: Congressional Budget Office.

NOTE: SMI = Supplementary Medical Insurance.

a. Includes impact of program savings on Hospital Insurance premiums.

b. Basic monthly SMI premium increases by $5 each year.

Medicare has grown faster than the federal budget and the economy for decades. The desire for a balanced budget has focused particular attention on Medicare spending in recent years, but the need for basic reform of the program has been evident far longer.

Adding to the pressure for Medicare reform is the impending depletion of the HI trust fund. Payroll taxes and other receipts under current law are not able to keep pace with the growth in spending for hospital and post-acute care services. Delaying the trust fund's depletion, even by a few years, would require substantial reductions in the growth of spending on those services or increases in payroll taxes.

Many policy options would reduce spending or increase revenues without altering the incentives that have propelled the growth of Medicare's spending over the past 30 years. Such options as reducing providers' payment rates and increasing beneficiaries' premiums could ease the financing crisis, at least in the short term, but could prove inadequate in preparing Medicare for the skyrocketing demand for services that is likely to occur as the baby-boom generation reaches age 65. Policies could be adopted to lay the groundwork for addressing the long-term financing crisis. Such policies would encourage greater efficiency in delivering services, as well as more realistic expectations on the part of providers and beneficiaries about Medicare's ability to finance those services.

The challenge for policymakers is to balance the need to control federal Medicare spending with the need to maintain reasonable access to care for beneficiaries. Nontraditional approaches to the pricing and delivery of care, such as broadening the range of eligible health plans, using market-oriented payment methods, or converting to a defined contribution system, could lead to a transformation of the Medicare program. If beneficiaries and providers accepted the lower spending levels as a permanent feature of Medicare rather than as a temporary feature, they would also be more likely to accept that transformation. Such a process could be an orderly one--if it was given enough lead time.

II. Medicaid

The Medicaid program, established under title XIX of the Social Security Act, is the nation's major program providing medical and long-term care services to certain low-income population groups. The federal and state governments jointly fund the program, but the states administer it. The program constitutes an open-ended federal entitlement for eligible people, with the federal government matching state expenditures at a rate that is based on a state's per capita income relative to the national average.

Medicaid generally covers four categories of low-income beneficiaries: the elderly, the disabled, children, and certain adults in low-income families (the majority of whom receive cash welfare benefits). Recently, however, the federal government has granted waivers to several states, allowing them to expand coverage to a broader low-income population. Children account for about one-half of all Medicaid beneficiaries, but because expenditures per child are relatively low, they represent less than one-fifth of Medicaid benefit payments. By contrast, the elderly and the disabled, who constitute only one-quarter of Medicaid beneficiaries, account for more than two-thirds of Medicaid benefit payments because of their more extensive needs for medical and long-term care.

The federal government specifies a list of services that Medicaid programs must cover. Those core services include inpatient and outpatient hospital services, physicians' services, laboratory and X-ray services, nursing facility and home health services for beneficiaries age 21 and older, nurse midwife and nurse practitioner services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment services for beneficiaries under age 21. States may also provide a wide range of optional services, and most choose to do so.

Although the federal government establishes the general criteria for Medicaid eligibility and covered services, the states retain considerable discretion over pro-

gram operations. As a result, the ability of the federal government to control its Medicaid spending is limited, and wide variations in eligibility, coverage, and spending exist among the states.

Recent Trends in Medicaid Spending

Federal Medicaid expenditures more than doubled between 1990 and 1996, soaring from $41 billion to $92 billion (see Table 5-10). That increase represented an average annual growth rate of more than 14 percent and drove Medicaid spending from about 3 percent to almost 6 percent of federal outlays. Spending growth was particularly dramatic in the first half of the period, averaging almost 23 percent a year between 1990 and 1993.

Two major factors contributed to that huge growth in spending: state initiatives to seek Medicaid coverage for programs that had previously been funded by the states alone, and the states' use of various financing schemes to generate matching funds for federal payments to so-called disproportionate share hospitals (DSH). Those schemes effectively enabled the states to draw down federal funds without generating the corresponding state matching amounts. Other contributing factors included the effects of the 1990-1991 recession, which resulted in significant growth in the Aid to Families with Dependent Children (AFDC) program, expansions of eligibility (some required by federal law and others that were optional for the states), new procedures to simplify enrollment, and higher payments for providers.

The federal government took steps in 1991 to reduce states' use of schemes involving illusory financing and to place limits on the growth of DSH payments. The Omnibus Budget Reconciliation Act of 1993 placed further curbs on the growth of DSH payments. Despite those measures, however, federal Medicaid spending still grew by almost 9 percent between 1994 and 1995.

Efforts to balance the federal budget, and concerns about Medicaid's role in those efforts, resulted in many proposals in 1995 and 1996 to change the underlying

Table 5-10.
Federal Outlays for Medicaid, 1990-1996 (By fiscal year)

	1990	1991	1992	1993	1994	1995	1996	Average Annual Rate of Growth, 1990-1996 (Percent)
Medicaid Outlays (Billions of dollars)	41.1	52.5	67.8	75.8	82.0	89.1	92.0	14.4
Percentage Change from Previous Year	18.8	27.7	29.1	11.8	8.2	8.7	3.3	n.a.
Medicaid Outlays as a Percentage of Total Federal Outlays	3.3	4.0	4.9	5.4	5.6	5.9	5.9	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

fiscal relationship with the states and slow the growth of Medicaid spending. Although they had several variants, those proposals took two basic forms: block grants and so-called per capita caps. Block grants would have imposed a ceiling on the amount of federal funds that a state could draw down in any year, whereas per capita caps would have placed limits on average federal expenditures per enrollee. Both types of measures were discussed extensively by the 104th Congress, but neither was enacted.

Toward the end of fiscal year 1996, the nature of the debate about Medicaid spending, and about the reductions in program spending needed to balance the budget, suddenly changed. The growth of Medicaid spending plummeted in the first six months of that year while the Administration and the Congress were discussing proposals to curb that growth. Although spending growth picked up in the second half of the year, the overall annual growth rate was only about 3 percent.

States' anticipation of block grants appears to have been instrumental in slowing Medicaid spending in 1996. The block grant proposals under discussion would have used states' 1995 expenditures as the base for determining the amount of their future block grants. Consequently, some states shifted spending into 1995, intending to increase that base amount. In addition, the prospect of limits on the rate of growth of federal Medicaid funds may have made states wary of expanding the program further in 1996. The strength of the economy and the resulting decline in AFDC enrollment also contributed to slower growth of Medicaid enrollment.

State Medicaid programs are now in flux. States are emerging from a year in which they anticipated major federal restructuring of the program that did not occur, and they are adapting to the welfare reform initiatives enacted in 1996. (Under that legislation, many legal aliens and some other recipients of Supplemental Security Income will lose their eligibility for Medicaid.) In addition, most states are attempting to restructure their Medicaid programs; rather than being passive payers of fee-for-service claims, they are trying to become more aggressive purchasers of health care and are shifting many beneficiaries into managed care programs.

Future Spending Growth and Its Implications

Projections of spending for entitlements are always uncertain, and the rapid changes that are occurring in the Medicaid program heighten that uncertainty. Nonetheless, there are several reasons to believe that the growth of Medicaid spending will be lower than previously anticipated, at least in the near term. Lower spending projections are causing some policymakers to question the need for further reductions in the rate of growth of federal Medicaid expenditures.

CBO released its latest Medicaid baseline projections for the 1997-2002 period in January 1997 (see Table 5-11). Those projections are $86 billion lower than the projections made in May 1996. In part, that lower baseline reflects actual 1996 Medicaid spending that is $4 billion lower than estimated, but the projected average annual rate of growth also dropped significantly, from 9.6 percent to 7.8 percent. Lower projections of enrollment played an important part in that reduction. Those projections reflected recent program experience, revised estimates of the effects of certain mandatory expansions of eligibility, revised demographic assumptions, and the effects of welfare reform. In addition, projections of inflation and the use of services were lower than last May.

But for a number of reasons, lower growth is by no means assured, and growth rates are likely to pick up again after the turn of the century. Large savings from expanded enrollment in managed care are unlikely, because Medicaid's fee-for-service rates are already low and because few states are enrolling the elderly and the disabled in managed care plans. Spending for certain Medicaid services used by the elderly and the disabled, especially noninstitutional long-term care and prescription drugs, has been growing rapidly, and there is no reason to believe those pressures will abate. Furthermore, in spite of federal legislation to curb schemes involving illusory financing, states still have the means to generate federal matching funds at little or no cost to themselves (by continuing to shift programs that are entirely state-funded into Medicaid, and through the use of so-called intergovernmental transfers on which there are no restrictions).

Thus, notwithstanding projections of slower growth in the short term, Medicaid is likely to continue to be a rising component of the federal budget, and unexpected upswings in expenditures are quite possible. In the long term, moreover, major growth in spending is almost inevitable as the population ages and a rising proportion needs nursing home care and home- and community-based services.

At present, however, the federal government has little ability to control its Medicaid outlays. Because it is obligated to match all state Medicaid spending without limit, sudden increases in state spending can cause unpredictable jumps in federal Medicaid outlays, with potentially damaging consequences for the federal budget. That situation arose in the early 1990s, when many states adopted illusory financing schemes to hike up DSH payments. Federal DSH payments rose from an estimated $500 million in 1990 to $10 billion in 1992.

The current debate on whether further action is needed to slow the growth of Medicaid spending tends to focus on short-term savings. Some people question, for example, whether additional savings from Medicaid are necessary to balance the budget by 2002, given the significantly lower projections of Medicaid spending. That question is one of priorities, which policymakers have to determine. If further savings are to come from Medicaid, then policymakers must decide on the strategy to generate those savings.

But the more important question about Medicaid may be structural. Should the Congress establish mechanisms to enable the federal government to exert more control over federal Medicaid outlays and to make those outlays more predictable, even if major savings are not sought at this time? The experience of the early 1990s suggests that such a strategy might be advisable.

Structural change, moreover, could be a two-way street. Most states would welcome changes in federal policy that would give them greater flexibility to run their programs. States, for example, would like to be able to enroll beneficiaries in managed care plans and expand coverage to new populations without obtaining federal waivers; be able to establish their own reim-

Table 5-11.
Projections of Federal Medicaid Outlays, 1997-2002 (By fiscal year)

	1997	1998	1999	2000	2001	2002	Average Annual Rate of Growth, 1997-2002 (Percent)
Medicaid Outlays (Billions of dollars)							
Benefits	84.4	89.9	97.0	104.9	113.5	123.0	7.8
Payments to disproportionate share hospitals	9.8	10.3	11.1	11.8	12.7	13.6	6.8
Administration	4.4	5.1	5.5	6.1	6.6	7.2	10.2
All Medicaid outlays	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Medicaid as a Percentage of Total Federal Outlays	6.0	6.2	6.4	6.5	6.8	7.0	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

bursement rates for hospitals and nursing homes, without the threat of legal challenges to those rates under the Boren amendment (which requires states to pay rates that are reasonable and adequate to meet the costs that would be incurred by facilities that were efficiently and economically operated); and have more control over covered services. Any changes along those lines would have to be carefully weighed, however, to ensure that beneficiaries' access to care and the quality of that care was maintained. Such safeguards would be particularly important if the fiscal relationship between the federal and state governments was also to change, limiting the commitment of federal financing for the Medicaid program.

This section explores possible approaches for slowing the growth of federal Medicaid spending. It focuses on the amount of control over federal outlays that different options would allow, and on the extent to which those options would change the underlying fiscal relationship with the states.

Overview of Policy Options

To illustrate the potential effects of alternative approaches for restructuring the federal/state relationship in the Medicaid program, this section reviews four generic policy options: using block grants, placing limits on average federal expenditures per capita (known as per capita caps), reducing DSH payments, and reducing federal matching rates. DSH payments would be folded into block grants but would maintain their separate status under the other three options.

For the purpose of comparison, each option assumes approximately the same overall savings target. (The different policy tools cannot be refined to the point of producing identical projected savings.) Three of the four options--block grants, per capita caps, and reductions in DSH payments--assume that the federal government would seek to constrain the annual rate of growth in Medicaid spending over the 1998-2002 period to be no greater than the average annual rate between 1996 and 1998. Under CBO's January 1997 baseline, Medicaid outlays are projected to grow at an average annual rate of 7.0 percent between 1996 and 1998, and at an average rate of 8.1 percent between 1998 and 2002. Although many different spending paths could result in an average annual rate of growth of 7.0 percent over the 1998-2002 period, the block grant, per capita cap, and DSH options in this chapter assume that the target rate of growth would be about 7.0 percent in each of those four years. (In practice, to ensure savings, such a policy might be structured so that the annual rate of growth over the 1998-2002 period could not exceed the lesser of the actual average rate of growth for 1996 through 1998 or the baseline rate for that same period.) Achieving that rate of growth would save between $12 billion and $14 billion through 2002, depending on the option.

The fourth option, reducing federal matching rates, assumes a savings target of about $13 billion over the 1998-2002 period. But because the policy would incorporate a single change in the level of matching rates that would be introduced in 1999 and stay in effect through the remainder of the period, achieving a uniform rate of growth of spending in each year would be almost impossible.

The degree to which the federal government could control federal Medicaid outlays, and thereby guarantee a given level of savings, would vary among the options. In general, the more a particular Medicaid option enabled states to influence the amount of federal spending, the greater the uncertainty associated with the projected federal savings. Options would also differ in their short-term and long-term consequences for federal control of spending; although each of the strategies would generate short-term savings, only two of them--the block grant and per capita cap options--would change the underlying fiscal relationship with the states.

Depending on their design, the various policy options could have significantly different distributional consequences for the states. Under current law, wide disparities occur in the amount of federal Medicaid funds that states receive relative to the size of their low-income population. (Low-income people are those in families whose income is less than 150 percent of the federal poverty level.) In 1994, for example, federal Medicaid spending per low-income person ranged from less than $800 in California, Florida, Idaho, Nevada, Oklahoma, and Virginia, to more than $2,000 in Connecticut, Massachusetts, New Hampshire, New York,

and Rhode Island.[4] The distribution of federal DSH payments is even more skewed; nine states received more than $250 per low-income person in 1994, and nine states received less than $10.

As long as Medicaid remains an open-ended matching program, one might argue that such disparities reflect the choices that states have made in allocating their own resources. But some states would probably view as inequitable any policies that linked states' future federal Medicaid funds to the amounts that they currently receive, locking in the current distribution of federal funds. Combined with constraints on future federal Medicaid spending, such policies would mean that low-spending states might not be able to expand their programs in the future even if they wanted to do so and were willing to put more of their own funds into Medicaid.

Distributional concerns might arise under three of the four policy options--block grants, per capita caps, and reductions in the rate of growth of DSH payments. Those policies could, however, be designed to reduce the existing inequalities in federal Medicaid payments among the states over time. To maintain budget neutrality, however, such a strategy would mean that federal Medicaid spending would have to grow more slowly than the overall target rate in states such as New York and Massachusetts if it was permitted to grow faster than that rate in other states, such as California and Florida.

The effects of alternative options on different beneficiary groups could also vary significantly and would depend on states' responses to those options. Because the options considered here would generate relatively small savings over the 1998-2002 period, however, their impact on beneficiaries would also be quite small during that period. But the block grant and per capita cap options would establish mechanisms that would enable the federal government to curb spending after 2002, and those options could have important implications for beneficiaries in the longer term.

In general, constraints on federal spending would probably result in lower overall Medicaid spending by the states. But how states chose to curb spending growth, and by how much, would depend in part on the amount of flexibility they were granted to manage their own programs and on the status of the federal entitlement to Medicaid benefits. Given sufficient flexibility, states might resort to a variety of strategies including increased enrollment in managed care plans, lower payments to providers, or cutbacks in eligibility or benefits. Keeping a federal entitlement would protect only those beneficiaries who continued to meet the eligibility criteria, and only for those services that states continued to cover.

Option 1: Use Block Grants

Block grants were among the most widely discussed mechanisms for controlling Medicaid spending in 1995 and 1996. The typical proposal, however, was not a block grant in the usual sense of a lump-sum payment to a state. Rather, block grants referred to ceilings on the maximum amount of federal Medicaid matching funds that a state could draw down in a year. The option discussed here adopts that definition.

Variations of the option might include only part of Medicaid spending in a block grant. DSH payments or payments for Medicare premiums for qualified Medicare beneficiaries might, for example, be handled separately from a block grant. On a broader scale, a block grant policy might cover only long-term care, allowing federal payments for acute care to remain open-ended. The rationale for such a policy would be that it is the costs of long-term care that pose the more serious threat to the federal budget in the future. But block-granting federal payments for long-term care could cause significant fiscal problems in the future for states with rapidly growing elderly populations.

Description of the Option

The most important attribute of a block grant is that a state cannot draw down more than a specified amount of federal Medicaid funds in any year. Once that ceiling had been reached, further expenditures of state Medicaid funds would not be matched by the federal government. In principle, the federal government would face no additional financial exposure, regardless

4. See David Liska and others, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1988-1994*, 2nd ed. (Washington, D.C.: Kaiser Commission on the Future of Medicaid, November 1996).

of economic conditions or actions by the states. The consequence of such a policy would be to end the federal entitlement to medical benefits for eligible individuals.

An important component of a block grant policy would be the selection of the year on which the block grant amount would be based. The intent of the option is that spending in 1998 should be no greater than the baseline projection for that year and that the rate of growth should be slowed to 7 percent thereafter. But if spending in 1997 turned out to be lower than projected, the option would seek to capture those savings. Thus, if the block grant policy contained no mechanisms to redistribute federal Medicaid funds among the states, then the amount of federal Medicaid funds that a state could draw down in 1998 would be the lesser of its 1996 spending, inflated by baseline rates of growth for 1997 and 1998, or its 1997 spending, inflated by the baseline rate of growth for 1998. The block grant amounts for each of the three subsequent years would be the 1998 amount inflated by 7 percent a year. Savings would be about $1 billion in 1999, rising to almost $6 billion by 2002 (see Table 5-12).

Implications of the Policy

Of the four policy options considered in this section, a block grant approach would come the closest to ensuring that the federal government met its savings targets for Medicaid. (Savings would be uncertain in the first year because the federal government would be obligated to pay Medicaid claims incurred before the new program was established.) To achieve those savings, however, the policy could not incorporate federal guarantees of medical coverage for particular population groups. Nor could it provide special protection for states with rapid growth in enrollment that would allow them to draw down additional funds, unless slow-growing states were more tightly limited. More generally, a block grant policy would not permit federal Medicaid funding to expand during recessions, placing all the risks associated with economic downswings on the states.

The implications for the states would depend in part on whether the policy also incorporated some mechanism for redistributing federal Medicaid funds among them. Such strategies might be relatively simple, such as transferring funds from states that did not use all of their annual allotments to states in which the capped amounts were binding. (Alternatively, states might be permitted to roll over any unused allotments to the following year.) The block grant proposals under discussion in 1995 and 1996, however, incorporated complex formulas that would adjust the growth rates of block grants on a state-by-state basis to reflect relative need, subject to ceilings and floors. Through the use of such formulas, federal Medicaid spending would grow faster than the target rate of growth in some states and slower in others.

Table 5-12.
Federal Medicaid Outlays Under the Block Grant Option, 1997-2002 (By fiscal year)

	Outlays (Billions of dollars)						Average Annual Rate of Growth, 1997-2002 (Percent)
	1997	1998	1999	2000	2001	2002	
Medicaid Outlays							
Under current law	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Under block grant	98.6	105.3	112.7	120.6	129.0	138.0	7.0
Savings		0	0.9	2.3	3.8	5.7	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

Because of concerns about their potential impact on beneficiaries, previous block grant proposals also included a variety of provisions requiring states to protect certain population groups. But the states would probably strongly resist any such provisions. As far as the states are concerned, an essential quid pro quo for any constraints on federal spending would be greatly increased flexibility to manage their programs, not new restrictions.

Option 2: Use per Capita Caps

In 1995 and 1996, various forms of proposals for per capita caps were the primary policy alternatives to block grants for constraining Medicaid expenditures. Those proposals, which policymakers are still considering, would typically limit average Medicaid expenditures per beneficiary but would allow total expenditures to grow as enrollment expanded. (Those expenditures would not include DSH payments, which would be handled separately.)

A per capita cap policy would not incorporate an unlimited federal entitlement for individuals. Instead, states would bear the full fiscal responsibility for excess spending if average expenditures per full-year-equivalent enrollee rose above the capped amounts.

Description of the Option

The per capita cap option described in this chapter uses the following assumptions:

- Each state would have separate limits on average annual per capita spending for four eligibility groups: the elderly, the disabled, children, and certain adults in low-income families. Those limits would be defined in terms of annual limits on average spending per full-year-equivalent enrollee.

- The limits in 1998 would be based on the lower of that state's per capita spending for each group in 1996, inflated by the projected growth rate of national per capita spending for 1997 and 1998, or the state's per capita spending for each group in 1997, inflated by the projected growth rate of national per capita spending for 1998. (That strategy, again, reflects the intent that 1998 spending should not exceed the baseline amounts but that the federal government should capture any savings resulting from spending in 1997 being lower than projected.) The per capita limits for 1999 and beyond would be based on the 1998 limits, inflated by the target rate of growth of national per capita spending for 1999 and subsequent years. The actual rates of growth incorporated into the policy, however, would depend on a variety of factors that could affect savings, including potential responses by the states to the policy (see below).

- The eligibility criteria and the mandatory and optional benefits for the program would be the same as under current law.

- A state's federal Medicaid expenditures in any year could not exceed the sum of the products of the per capita cap amount and the number of full-year-equivalent enrollees for each eligibility group. That is, federal Medicaid expenditures would be fungible so that expenditures below the total limit for one group could offset excess expenditures for another group.

- DSH payments would be the same as under current law.[5]

Reducing growth rates of Medicaid spending to about 7 percent a year between 1998 and 2002 would require setting growth rate targets for per capita expenditures of about 4 percent a year over that period. Achieving those rates would lower the average annual growth rate of per capita spending from 6.3 percent to 4.3 percent between 1997 and 2002 (see Table 5-13). Because per capita spending for children and the disabled would grow faster under current law than per capita spending for the elderly and other adults, the rate of growth of per capita spending under the policy would fall more for children and the disabled than for the other two groups. The assumption of fungibility would, however, allow a state's actual per capita expenditures to grow faster than the target rates in some groups, if they grew

5. In reality, those payments might have to be reduced because of the slower growth in Medicaid's payments for medical assistance.

more slowly in others and if the state did not exceed its overall limit on annual expenditures.

Implications of the Policy

Per capita caps would provide less protection for the federal budget than a block grant would offer, but they would give more flexible financial support to states with rapidly growing low-income populations. A per capita cap policy could not guarantee a certain level of federal savings because the federal government would continue to share with the states the fiscal risks associated with macroeconomic uncertainty. If unemployment or poverty rates rose, thereby expanding Medicaid enrollment, federal and state Medicaid expenditures would both increase correspondingly. How the states responded to the policy could also affect federal savings. States would have incentives not only to run their programs more efficiently but also to enroll more lower-cost and fewer higher-cost beneficiaries within each eligibility group and, when possible, to classify beneficiaries into groups with higher per capita caps.

Inadequate data, moreover, could limit the federal government's ability to enforce a per capita cap strictly,

Table 5-13.
Federal Medicaid Outlays Under the Per Capita Cap Option, 1997-2002 (By fiscal year)

	1997	1998	1999	2000	2001	2002	Average Annual Rate of Growth, 1997-2002 (Percent)
Outlays (Billions of dollars)							
Under Current Law	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Under per Capita Cap	98.6	105.3	112.4	120.3	128.6	137.6	6.9
Savings		0	1.2	2.5	4.2	6.2	n.a.
Average Spending per Full-Year-Equivalent Enrollee Under Current Law (Dollars)							
Elderly	6,650	6,950	7,260	7,670	8,100	8,600	5.3
Disabled	5,410	5,740	6,130	6,500	6,900	7,350	6.3
Children	860	910	970	1,030	1,100	1,160	6.2
Adults	1,400	1,450	1,530	1,610	1,700	1,790	5.0
All Enrollees	2,460	2,590	2,750	2,930	3,120	3,340	6.3
Average Spending per Full-Year-Equivalent Enrollee Under per Capita Cap (Dollars)							
Elderly	6,650	6,950	7,230	7,520	7,820	8,130	4.1
Disabled	5,410	5,740	5,970	6,210	6,460	6,720	4.4
Children	860	910	950	990	1,030	1,070	4.5
Adults	1,400	1,450	1,510	1,570	1,630	1,700	4.0
All Enrollees	2,460	2,590	2,690	2,800	2,910	3,030	4.3

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

at least in the early years of the policy. Effective enforcement would depend on the availability of reliable, detailed data on expenditures and enrollment from the states, possibly requiring new or expanded reporting systems. CBO's estimates incorporate a 30 percent offset to savings that reflects the combined effects of the states' responses to the per capita limits and the difficulties in monitoring and enforcing those limits.

As with block grants, concerns about equity would probably arise if a per capita cap policy did not also redistribute federal funds among the states. States that had operated their Medicaid programs more efficiently than others in the past might find it harder to keep average expenditures below the cap amounts because they would have less "fat" to trim. Moreover, states that currently have lean benefit packages would find it difficult to expand benefits in the future, if they wanted to do so.

Option 3: Reduce DSH Payments

DSH payments currently account for almost 10 percent of federal Medicaid outlays. Reducing those payments would be a relatively straightforward way to generate Medicaid savings. Using that strategy, the rate of growth of total Medicaid spending could be trimmed to about 7 percent a year over the 1998-2002 period, taking all of the reductions out of DSH payments.

Description of the Policy

Under current law, DSH payments may not exceed 12 percent of Medicaid's medical assistance payments, nationwide. Under that policy, DSH payments can con-

Table 5-14.
Federal Medicaid Outlays Under the Option to Reduce Payments to Disproportionate Share Hospitals, 1997-2002 (By fiscal year)

	Outlays (Billions of dollars)						Average Annual Rate of Growth, 1997-2002 (Percent)
	1997	1998	1999	2000	2001	2002	
DSH Payments							
Under current law	9.8	10.3	11.1	11.8	12.7	13.6	6.8
Under option	9.8	10.3	10.0	9.0	8.0	6.5	-7.9
Medicaid Outlays							
Under current law	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Under option[a]	98.6	105.3	112.8	120.7	129.3	138.4	7.0
Savings		0	0.8	2.1	3.5	5.3	n.a.

SOURCE: Congressional Budget Office.

NOTE: DSH = disproportionate share hospital; n.a. = not applicable.

a. Assumes that spending for other Medicaid services would increase.

tinue to grow as long as medical assistance payments grow. The option considered here, however, would place dollar limits on annual DSH payments that would not be affected by the growth of medical assistance payments.

Reducing the rate of growth of federal Medicaid outlays to about 7 percent a year during the 1998-2002 period would generate steadily increasing savings. Under the policy, DSH payments would be constrained to the baseline level of $10.3 billion in 1998 and would fall to $6.5 billion by 2002, or less than half of the baseline amount for that year (see Table 5-14). Some of the savings would be offset, however, by higher spending for other Medicaid services.

Implications of the Policy

Reducing DSH payments--in effect, capping the total amount that the federal government would pay--would be an administratively simple way to generate savings. But although capping DSH payments would limit the ability of the states to use certain financing schemes to generate federal funds, the fundamental underlying fiscal relationship with the states would not change. In the long term, therefore, this approach would do little to enable the federal government to gain control of federal Medicaid spending.

Under current law, states whose DSH payments are more than 12 percent of their medical assistance payments may not increase their DSH spending. States whose DSH payments are below 12 percent can increase their DSH payments up to an allotment amount that increases each year at the same rate as their medical assistance payments. A policy that placed an absolute annual limit on DSH payments would have to incorporate a method for allocating that annual amount among the states. If the basic structure of the current system was unchanged, policymakers would have to determine whether the reductions in states' DSH payments should be proportional, or whether states with high DSH payments should face greater or lesser relative reductions than states with low DSH payments. Given the inequities of the current distribution of DSH payments among the states, however, changing the structure of the program might seem preferable. The current system could, for example, be replaced by a system of targeted payments for "safety net" hospitals and other health care providers serving large numbers of low-income people.

How the policy allocated DSH funds among the states would affect their responses to the reductions. States losing a significant proportion of their DSH funds would probably increase their spending on other Medicaid services. Hence, the estimates of the option incorporate a 25 percent offset to savings.

Option 4: Lower Federal Matching Rates

Reducing federal matching rates would mean that states would receive fewer federal dollars for each state dollar that they spent on Medicaid. Such a policy would be relatively simple to implement because it would involve little other change to the existing Medicaid program.

Under current law, the federal government uses a formula that is based on a state's relative per capita income to determine the federal medical assistance percentage (FMAP), or matching rate, for the Medicaid program.[6] The FMAP may not be greater than 83 percent or less than 50 percent. The 83 percent ceiling is not currently a binding constraint; Mississippi had the highest FMAP in 1996 at 78 percent. But the 50 percent floor benefits the states with the highest per capita income (11 states and the District of Columbia in 1996) and, in some cases, makes a dramatic difference in the amount of federal funds they receive. Without the floor, the District of Columbia would have had a federal matching rate of 12 percent in 1996. The rate for Connecticut would have been 18 percent; for New Jersey, 25 percent; and for New York, 36 percent.

Description of the Option

Two alternatives for reducing federal matching rates are explored here: reducing the rates by the same proportion for all states, or lowering the floor percentage. The

6. The formula is FMAP=100*(1-[state per capita income^2/U.S. per capita income^2]*0.45).

estimates of those alternatives assume that states would elect to use their own funds to make up some of the difference between the federal funds they would have received under the old FMAP and those they would receive under the lower FMAP (if their contribution did not change).

Assuming that the states took no other action to reduce the effects of the policy, achieving $13 billion in savings over the 1998-2002 period would require a proportional reduction of 1 percent in all FMAPs beginning in 1999 (see Table 5-15). Under the option to lower the floor only, the new floor in 1999 would be 47.25 percent. But knowing that their FMAPs would be lower in 1999, some states might shift Medicaid spending from 1999 to 1998 to obtain a higher matching rate. Thus, to ensure that the $13 billion savings target was achieved, the policy could be designed so that the FMAP reductions in 1999 would be greater if 1998 spending exceeded the baseline projection.

Under both of the FMAP alternatives, savings would be distributed more evenly between 1999 and 2002 than under the three previous policy options. That pattern of savings would result because the policy would require a change in the level of matching rates in 1999 that would stay in effect throughout the period. Nonetheless, annual fluctuations in states' relative per capita income could still produce marginal changes in individual states' matching rates during the period.

Implications of the Policy

A policy to lower federal matching rates would place no limits on the amount of federal funds that states could draw down and would leave the federal entitlement for individuals unchanged. Consequently, even though states would have to pay a higher price for every federal dollar that they received, the federal fiscal obligation to the states would remain completely open-ended. Sav-

Table 5-15.
Federal Medicaid Outlays Under Options to Change Federal Matching Rates, 1997-2002 (By fiscal year)

	Outlays (Billions of dollars)						Average Annual Rate of Growth, 1997-2002 (Percent)
	1997	1998	1999	2000	2001	2002	
Reduce Federal Matching Rates by 1 Percent							
Medicaid Outlays							
Under current law	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Under option	98.6	105.3	110.8	119.8	129.5	140.2	7.3
Savings		0	2.9	3.1	3.3	3.6	n.a.
Reduce the Floor for the Federal Matching Rate to 47.25 Percent							
Medicaid Outlays							
Under current law	98.6	105.3	113.6	122.9	132.8	143.8	7.8
Under option	98.6	105.3	110.7	119.7	129.4	140.1	7.3
Savings	0	0	2.9	3.1	3.4	3.6	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

ings would be uncertain, therefore, and the federal government would gain no effective control over Medicaid spending.

Uncertainty about federal savings arises because those savings would depend on states' responses to lower matching rates. Those responses would reflect two opposing incentives. Because every state Medicaid dollar would generate fewer federal dollars, states would have incentives to reduce their financial commitments to the program. But some states might choose to increase their expenditures in order to lessen the impact of the federal reductions. If states made up more of the difference than assumed in the estimates in this chapter, savings would be lower (and the converse). The more of their own funds that states spent, the more federal funds they would draw down and the greater the reduction in matching rates necessary to achieve a given level of federal savings.

Reducing federal matching rates proportionately would have a relatively greater fiscal impact on states with higher matching rates. For example, under a 1 percent reduction in matching rates, a state with an FMAP of 70 percent would lose $0.70 for every $100 of state expenditures, whereas a state with an FMAP of 50 percent would lose $0.50 for every $100 of state expenditures. By contrast, lowering the floor for federal matching rates would affect only those states with the highest per capita income.

Conclusions About Medicaid

Given the recent reductions in the projected rate of growth of Medicaid spending, policymakers have differing opinions about the need to seek further Medicaid savings. Projections of future Medicaid spending are highly uncertain, however, and at present, the federal government has no effective means to control its expenditures for that program. Consequently, even if policymakers are not looking for major savings in the program, they might consider establishing mechanisms to enable the federal government to exert more control over its outlays for Medicaid in the future. Policies to achieve that goal could be accompanied by measures granting the states greater flexibility to run their Medicaid programs.

All of the approaches discussed in this chapter would expose the states to greater financial risks and give them incentives to manage their program more efficiently. States might also respond by reducing payments to providers and cutting back on eligibility and covered services.

The four options vary in the degree to which they would guarantee federal savings. After the first year or so, a block grant could ensure that federal Medicaid outlays would not exceed a target amount. Under that approach, the federal entitlement to benefits for individuals would end, and the states would bear all of the financial risks associated with economic downturns.

A per capita cap policy would enable the federal government to exert some control over future Medicaid outlays, but the degree of control would not be as tight as under a block grant. Such a policy would maintain a capped federal entitlement for individuals and, by allowing federal financing to increase with Medicaid enrollment, would require the federal government to share macroeconomic risks with the states. The states' responses to the new policy would also affect federal savings, which would not be the case with a block grant.

The other two options--reducing DSH payments and lowering federal matching rates--would generate savings but would do little to change the underlying fiscal relationship with the states. The federal entitlement to benefits would continue, and the federal government's financial commitment would remain completely open-ended. Reducing DSH payments might, however, be part of a broader policy to redirect those payments to safety-net hospitals and other health care providers serving large numbers of low-income people.